Why should the rich care about the health of the poor?

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Doctors, many of them wealthy, are concerned about the health of the poor. That hardly needs explaining. However, the more general question of why the rich should care about the health of the poor merits further inquiry. I argue that the reasons are regard for self-interest and regard for others, both of which involve our understanding of social inequality.

Before exploring why the rich should care about the health of the poor, we would do well to describe the problem correctly. The poor have worse health than the rich — a widespread phenomenon — but that is only part of the problem. In Canada,[1] the United States,[2] the United Kingdom[3] and most European countries,[4] health follows a social gradient: the lower the position in the social hierarchy, the worse the health and the shorter the life expectancy. Therefore, not only should we be concerned about the poor health of the poor, but about the whole social gradient of health, which includes the whole of society. Everyone below the very top level has worse health than those above them. The challenge, then, is to do something about the health of not only the poor but the whole of society.

So, why should the rich care about the social gradient in health? One reason is that we are all involved. The self-interest of the moderately rich should make them concerned that their health is not as good as that of the very rich, and the self-interest of the comfortable middle socioeconomic groups should make them concerned that their health lags behind that of the moderately rich.

There is another, deeper, argument. The Commission on Social Determinants of Health (CSDH),[2] which I chaired, affirmed the judgment that socioeconomic inequalities in health arise from socioeconomic inequalities in society. The commission, set up by the World Health Organization (WHO), concluded that health inequities arise from the conditions in which people are born, grow, live, work and age. Inequities in power, money and resources result in inequities in the conditions of daily life. Thus, the social gradient in health, and the poor health of those at the bottom of the social ladder, tell us something fundamental about inequality in society. It is not fanciful to make a link between the protests of the *indignados* (the outraged) on the streets of Spain (where youth unemployment is 50%),[5,6] the supporters of the “99%” who occupied New York City’s Zuccoti park, the Occupy movement’s tents outside St Paul’s Cathedral in London, UK, and the social gradient in health. Each of these phenomena highlight the consequences of inequality in society.

One might ask whether framing the argument in this context is merely shifting the topic. I argue that we should be concerned with inequalities in health because they tell us something fundamental about inequalities in society. For those who might question why they ought to care about such things, among other reasons, social inequality damages social cohesion. As authors such as Michael Sandel and the late Tony Judt have argued,[7,8] where inequalities in society are high, the very nature of society is under threat. The rich and poor inhabit different parts of cities, their children go to different schools, and they take their recreation in different places. As the rich increasingly pay for their own solutions, they become intolerant of their tax dollars being used to support others in society, furthering social division.

That it does not have to be so is apparent in the Canadian approach to health care. When I visit Canada, I am told repeatedly that Canadians have deep respect for the basic decency and justice of a health care system that is universal regardless of one’s ability to pay. Universal health care is good not just because it provides care to the least fortunate members of Canadian society, but because it is a very tangible expression of the cohesion of that society.

The argument from self-interest and that from concern for others share common ground. For

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Key points

- There is a social gradient in health — everyone below the very top level of wealth has worse health than those above them.
- Socioeconomic inequalities in health arise from socioeconomic inequalities in society, including the conditions in which people are born, grow, live, work and age.
- Social inequality damages social cohesion, which may lead to violence (insecurity), and violates our sense of fairness.
- As doctors, we have a special responsibility to address the social inequalities that give rise to health inequity.

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example, the more unequal a society, the greater the rates of crime and civil unrest. Latin America, with very high levels of income inequality, has high rates of homicide.[9] The rich suffer from living in a society marked by high levels of inequality. Most middle-class people living in the more violent Latin American cities have a story to tell about personally experiencing violent crime. It is deeply, personally, threatening to live in a very unequal society.

Social inequality also violates our sense of fairness. Why should some of us have so much when others, manifestly, suffer from having so little? Whether you call that self-interest — feeling uncomfortable living in an unfair society — or concern for the unnecessary suffering of others is irrelevant. What is important is that living in an unfair society should matter to us. There is a very real cost to the growing social and income inequalities that we have tolerated in so many of our societies. One manifestation of this is the size of the social gradient in health.

But what if the poor bring their ill health down upon their own heads as a result of irresponsible behaviour; is it still reasonable to consider that to be a symptom of an unfair society? The facts contradict such an argument. If a single poor person smoked, drank to excess and was obese, one could wonder at the apparent lack of self-control. However, the evidence tells a different story. Smoking follows the social gradient, as does obesity in women; the lower the position on the social ladder, the greater the level of smoking and obesity.[3] It is not useful to attribute such a social trend to a failure of personal responsibility. For example, to blame the unemployed for the fact of their unemployment is to ignore the trends in the economy that lead to unemployment. As the commission argued, we must address the social conditions that enable people to take control of their lives and make informed lifestyle choices.

There is an important philosophical discussion to be had about which is more salient: inequalities in opportunities or inequalities in outcomes. The answer is almost certainly both. As doctors, we have a special interest in social inequalities in society — not only because they limit opportunities, but because they affect the outcomes of health. Social inequalities in health that are judged to be avoidable by reasonable means are unfair. As doctors, we have a special responsibility to address the social inequalities that give rise to such health inequity.

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Editor's note: Sir Michael Marmot will deliver a Special Lecture on "Fair Society, Healthy Lives" on Aug. 13, 2012, at the CMA Annual Meeting in Yellowknife, NWT.